City of Boston
Employee Request for Coronavirus Emergency Paid Sick Leave

(*Applicable to Emergency Responders & Non-Emergency Responders*)

You must provide as much advance notice as reasonably practicable in order to apply for leave. Please submit the completed form to covidleave@boston.gov.

I. Employee Information

Please check your designation as:

☐ **Emergency Responder** ☐ **Non-Emergency Responder**

Employee Name: ____

Employee ID #: ____________________ Department: ______________________________

Title: ____

Employee Phone Number: ____

Employee E-Mail Address: ____

II. Request for Leave

Anticipated date the leave is to begin: ____

Expected return to work date: ____

Purpose for the Leave:

I am unable to work because of the following purpose (select the most appropriate box and provide any additional required information)

☐ **Purpose 1**: I am subject to a federal, state or local quarantine or isolation order related to COVID-19.

a. Provide the name of the government entity issuing the order:

____

b. Provide the date through which you must self-quarantine or isolate:

____

☐ **Purpose 2**: I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

a. Provide the name of the health care provider issuing the advisement:

____

b. Provide the reason you have been advised to quarantine (exposure, underlying condition, etc.):

____

☐ **Purpose 3**: I am experiencing symptoms of COVID-19 and seeking a medical diagnosis.

Provide the status of your COVID-19 testing:

☐ Attempting to make an appointment for a COVID-19 test

☐ Waiting for a scheduled appointment for a COVID-19 test

☐ Awaiting results from a COVID-19 test

☐ Tested positive

a. If you have been tested, please provide the date:

____

b. I hereby certify that if I test positive for COVID-19 I will not return to work until cleared by my medical provider. If I use an electronic signature below it shall constitute my authentic signature.

Employee Signature: ____

☐ **Purpose 4**: I am caring for an individual who is subject to an order as described in purpose 1 above or who has been advised to quarantine as described in purpose 2 above.

a. Provide either the name of the government entity issuing the order or the health care provider issuing the advisement:

____

b. List the name of the individual you are caring for and the individual's relationship to you:

____

☐ **Purpose 5**: I am caring for a child[1] whose elementary/secondary school, place of care or child care provider has closed due to COVID-19 precautions.

a. Provide the name of the school/place of care/child care provider:

____

b. Provide the name and age(s) of the child/children being cared for:

____

c. I hereby certify that no other suitable person is available to care for my child/children during the period of requested leave. If I use an electronic signature below it shall constitute my authentic signature.

Employee Signature: ______________________________________

☐ **Purpose 6**: I am experiencing a substantially similar condition to COVID-19 as specified by the U.S. Department of Health and Human Services.

☐ **Purpose 7**: I received an immunization for COVID-19, and

☐ My appointment took longer than an hour.

Please <u>provide information</u> showing that you received your immunization, and documentation indicating the date of the immunization, length of time it took, and where received your immunization.

☐ I am recovering from an injury, disability, illness, or condition related to the immunization. *Please <u>provide information</u> showing that your injury, disability, illness, or condition, including without limitation the date of onset.*

---

[1] A child is defined as an employee's own child, adopted child, foster child, step child, legal ward, or child for whom the employee stands in loco parentis who is (1) under eighteen (18) years of age; or (2) is over eighteen (18) years of age and has a mental or physical disability and is incapable of self-care because of that disability.

☐ **Purpose 8**: I am caring for a family member who received is obtaining immunization for COVID-19 or who is recovering from an injury, disability, illness, or condition related to the immunization.

Please provide information showing that your injury, disability, illness, or condition including, without limitation the date of the immunization and the length of time of the injury, disability, illness, or condition.

III. Emergency Paid Sick Leave Benefit

Full-time employees are entitled to two weeks of paid sick time capped at eighty (80) hours under the Emergency Paid Sick Leave. Part-time employees are entitled to paid sick time under the Emergency Paid Sick Leave for a number of hours equal to the number of hours that such part-time employee works on average over a two (2) week period, capped at eighty (80) hours.

Paid sick leave under the Emergency Paid Sick Leave is 100% of the employee's regular rate of pay for leave under purposes 1, 2, 3, 6, and 7 above.

Paid sick leave under the Emergency Paid Sick Leave is at the employee's regular rate of pay up to a maximum of $200.00 per day for the first five days used and 2/3 the employee's regular rate of pay up to a maximum of $200 per day for the next five days used if used for purposes 4, 5, and 8 above.

IV. Certification

I understand that I may be required to provide additional documentation and/or a fitness to return to work certification. I acknowledge that it is my responsibility to contact my manager prior to returning to work. I also understand that if I am unable to return to work/telework on the above date, I must obtain approval for an extension of my leave. I certify that the information provided herein is accurate, complete, and true. If I use an electronic signature below it shall constitute my authentic signature.

Employee Signature: ____

Date: ________________________________

FOR HR USE ONLY

Date Received: ________________________

Date Processed: ________________________